Break of Day Mental Health Group, Inc.

Adult Services Referral Form

Name:			Date of Referral:
Street Address/PO Box:			Date of Birth:
Town:	State:	Zip Code:	Phone:

Consent Decree Class Member? ☐ Yes ☐ No

MaineCare #:	SS#:	Medicare: ☐ yes ☐ no #:
Referred by/Agency:		Phone:

Service(s) requested:

☐ Community Integration/Case Management (CI)	☐ Skills Development (SD) Services
☐ Outpatient Therapy (OP) Services	Hours requested per week:_____
☐ Representative Payee (RP) Services	☐ Daily Living Support (DLS) Services
☐ Nurse Consultant	Hours requested per week:_____

Briefly describe the needs you have that you expect assistance from the above program(s) with:

Do you have a staff preference?

☐ Male Only ☐ Female Only ☐ No Preference

Please include all of the following required documentaton:

- ☐ Signed Authorization to Release Information to Break of Day Mental Health Group, Inc. – all programs
- ☐ Copy of the applicant's current ISP (Completed within 90 days) – for Skills or Daily Living Support Services
- ☐ Copy of Current LOCUS Assessment (Completed within 1 year) – for Skills or Daily Living Support Services
- ☐ Copy of Current Diagnostic Information (Completed & signed within 1 year) – for Community Integration, Skills or Daily Living Support services

Other helpful documentation:

☐ Discharge Information (if applicable) – all programs	☐ Crisis Plan – all programs
☐ Comprehensive Assessment – all programs	☐ Medication List – all programs
☐ MH Advance Directive (if available) – all programs	☐ AC-OK screening form – CI, Outpatient referrals

Signature of Client Client Printed Name Date

Signature of Referral Source Referral Source Printed Name Date

Office Use only:

Referral Rec'd:	APS PA:	Extended Stay:
Staff Assigned:	Intake Date:	Referral Closed:

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